

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

25631
Do not use this space.

1. PLACE OF DEATH 2
(a) County Linn Registration District No. 496
(b) Township Brookfield Primary Registration District No. 3025
(c) City Brookfield (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Lawrence Henry Collier
(a) Residence, No. 542 Harrison St. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) _____

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Alice Collins - 68

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 22 - 1860

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>79</u>	<u>9</u>	<u>9</u>	

OCCUPATION

8. Trade, profession, or particular kind of work done, as a lawyer, bookkeeper, etc. Coal miner

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) New York City 1 N. Y.

FATHER

13. NAME John Collins. 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) N. Y. 5

MOTHER

15. MAIDEN NAME Maggie O'Byan

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) A. B. Smith Brookfield Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Brookfield DATE Aug 24

19. FUNERAL DIRECTOR (NAME) (ADDRESS) E. B. [unclear] [unclear] Mo

20. FILED Aug - 1 - 40 Brookfield Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 31 1940

22. I HEREBY CERTIFY, That I attended deceased from Mar. 12, 1940, to July 31, 1940
I last saw him alive on July 31, 1940 Death is said to have occurred on the date stated above, at 5:30 P.M.
The principal cause of death and related causes of importance were as follows:
Ac. Myocardial Infarct.
Other contributory causes of importance: Arteriosclerosis
Date of onset July 26

Name of operation None Date of _____
What test confirmed diagnosis? Usual Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify _____
(Signed) J. Evans M. D.
445 (Address) Brookfield Mo

RECEIVED
District Health Officer No. 11,
District File Number 846-1047
Date Filed 1961-9-17

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....
Licensed Embalmer No.....
P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.